

DD Waiver Individual Choice of Providers Form

Individual's Name: _____

The Case Manager of the Individual and Family with Developmental Disabilities Waiver has discussed all of the current waiver provider options with me.

I am aware of the fact that I may contact the Case Manager at any point in the future to discuss other Waiver provider options.

I am aware of the fact that I may contact the Case Manager at any point in the future to change my current Waiver provider(s) and services.

I am aware of the right to a fair hearing and the appeal process.

I have the potential to have a patient pay amount, based on my income, regardless of the amount of institutional or community based care received.

I understand that, by using Consumer-Directed Services, I bear the responsibilities associated with employing my own personal attendants. Note: DMAS is not the employer for Consumer-Directed Services.

The individual's (or authorized representative's) consent to exchange information with the Department of Medical Assistance Services (DMAS) by signing and dating this form. This consent will remain in effect until revoked by the individual (or authorized representative) in Writing.

The above information has been discussed with me. I understand that the case manager and provider will develop a Plan of Care with my assistance based on my needs and my available support. Provider staff is responsible to provide continuous and reliable care. I understand that when there is a lapse in service I am responsible to provide back-up support.

From the list of Waiver providers given to me by my case manager, I have chosen the following:

SERVICES	PROVIDERS
In-Home Residential Support	_____
Day Support	_____
Adult Companion Care	_____
Assistive Technology	_____
Consumer-Directed Respite	_____
Consumer-Directed Personal Care	_____
Consumer-Directed Companion Care	_____
Environmental Modifications	_____
Family/Caregiver training	_____
Agency Personal Care	_____
Personal Emergency Response System	_____

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Respite Care		_____
Skilled Nursing Services		_____
Supported Employment		_____
Prevocational Services		_____
Case Management (SPO)		_____
Crisis Stabilization		_____
Therapeutic Consultation	Occupational	_____
	Physical	_____
	Speech	_____
	Social Work	_____
	Recreational	_____
	Rehabilitation	_____
	Psychological	_____
	Psychiatric Clinical Nursing	_____

_____	_____
Individual's Signature	Date
_____	_____
Parent / Guardian Signature	Date
_____	_____
Case Manager's Signature	Date